☐ **EXPEDITED REQUEST**
***If checked, return to DOI within 24 hours**

STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE

INDEPENDENT MEDICAL REVIEW PROGRAM
REQUEST FOR INSURANCE COVERAGE INFORMATION (RICI)

The Department of Insurance (DOI) has received a request from an insured for an Independent Medical Review (IMR) related to the following health care service dispute:

Insurance Company Name:_____
Disputed medical service or treatment:_____
Insured's Name:_____ Address:_____
SSN:_____ DOB:_____
Patient's Name:_____ Policy No.:_____
Policyholder's Name:_____ Claim No.:_____

In order to process the IMR application, DOI is requesting additional benefit information. Please provide the answers that apply to the following:

☐ Confirmation that health coverage was in force on the date of service. **Yes / No** Termination date:__/__/__

☐ Attach a copy of the insurer's letter , appeal /grievance response specific to the dispute noted above. If applicable, please attach relevant underlined segments of the insurance policy.

Reason for denial was based on which of the following determinations: (Check all applicable boxes)

Benefit Coverage		Medical Necessity	
Experimental/Investigation Treatment		ER or Urgent Care Claim Denial	
Medication Denial		Denial of Mental Health Services	

☐ Please provide the ICD-9, CPT-4 or other codes appropriate for the insured's condition and requested services.
ICD – 9 code(s):_____ CPT – 4 or other service code:_____

☐ Are the medical services requested or rendered by an HMO, PPO, POS or Indemnity?_____
☐ Has the treatment been rendered to the insured? **Yes / No**
☐ Please indicate the date the insured's appeal/grievance was received. __/__/__.
☐ Please indicate the date the appeal/grievance was resolved. __/__/__.
☐ Was the appeal/grievance resolved? Yes / No If Yes, Briefly Explain:_____

List names and specialties of physicians or clinical staff involved in the review of this case.
_____

Name and specialty of the treating physician:_____

☐ Is the insured covered by Medicare? **Yes / No** If Yes, is there other coverage? **No / Yes**
If Yes, Briefly Explain:_____

DATE RICI FAXED TO INSURER: __/__/__
DATE OF INSURER'S RESPONSE __/__/__

Important Response Times: Insurer's response for Expedited Requests is 24 hours from date of fax. Insurer's response time for Standard IMR Requests is 3 calendar days from date of fax.

Please fax this form and attachments to DOI: Fax # (213) 897-5891 ATTN: IMR UNIT

If you have any questions, please contact_____